

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/20/2014  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |                            |  |
|--|--|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>155275</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R-C</b><br><b>11/13/2014</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WATERS OF PRINCETON THE</b> |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1020 W VINE ST</b><br><b>PRINCETON, IN 47670</b>                             |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |  |
| {F 000}  | <p>INITIAL COMMENTS</p> <p>This visit was in for the Post Survey Revisit to the Investigation of Complaint IN00154633 and IN00156570 completed on October 2, 2014.</p> <p>This visit was in conjunction with the for the Investigation of Complaints IN00158056 and IN00159151.</p> <p>Survey dates:<br/>November 12,13, 2014</p> <p>Facility number: 000175<br/>Provider number: 155275<br/>AIM number: 100274440</p> <p>Survey Team:<br/>Sylvia Scales, RN-TC</p> <p>Census bed type:<br/>SNF/NF: 66<br/>Total: 66</p> <p>Census payor type:<br/>Medicare: 8<br/>Medicaid: 52<br/>Other: 6<br/>Total: 66</p> <p>Sample: 5</p> <p>The Waters of Princeton was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of IN00154633 and IN00156570.</p> <p>Quality review completed on November 14, 2014 by Jodi Meyer, RN</p> | {F 000}  |  |                            |  |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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